STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085037	A. BUILDING _____ B. WING _____	C 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced complaint survey was conducted at this facility from July 22, 2019 through July 24, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 163. The survey sample totaled 10.

Abbreviations and Definitions used in this report are as follows:

Acute renal failure - kidneys suddenly cannot remove waste products from the blood;
ADON - Assistant Director of Nursing;
AIMS (Abnormal Involuntary Movement Scale) - a rating scale to measure involuntary movements of the face, mouth, trunk, or limbs known as tardive dyskinesia that sometimes develops as a side effect of long-term treatment with antipsychotic medications;
Antipsychotic - medication used to treat psychosis and other mental/emotional conditions;
BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15:
13-15: Cognitively intact
8-12: Moderately impaired
0-7: Severe impairment
CNA - Certified Nurse's Aide;
Cognition - mental processes or thinking;
Cognitively impaired - abnormal mental processes/thinking;
Cognitively intact - able to make own decisions;
Delusion(s) - false belief thought to be true;
Dementia - brain disorder with memory loss, poor

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/21/2019

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F 000	Continued From page 1	F 000		

judgement, personality changes and disorientation;
DON - Director of Nursing;
Edema Severity Rating;
1+ = can press down 2 mm or less, slight pitting, indentation disappears rapidly
2+ = can press 2-4 mm, somewhat deeper pit, indentation disappears in 10-25 seconds
3+ = can press down 4-6 mm, pit noticeably deep and may last more than a minute
4+ = can press down 6-8 mm, pit very deep and lasts over 2 minutes
Extensive assistance - resident involved in activity, staff provide weight-bearing support
Hydrated - having enough liquid / water in the body;
IV (intravenous) - insertion of small tube into the vein to give fluids;
Limited assistance - resident highly involved in activity, staff provide guided movement of limbs or other non-weight bearing assistance;
LPN - Licensed Practical Nurse;
MD - Medical Director;
MDS - Minimum Data Set Assessment;
Mentation - thought process;
mL (milliliters) -unit of liquid volume, 5 ml equals 1 teaspoon;
Moderate cognitive impairment - decisions poor, cues / supervision required;
Namaste room - room incorporating sensory solutions to relax:
NHA - Nursing Home Administrator;
Ombudsman - one who advocates for residents in long term care facilities;
Postural hypotension - blood pressure drops when changing positions like laying to sitting, may cause dizziness;
Psychosis - loss of contact/touch with reality;
Psychoactive medication - drug used to change

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F 000	Continued From page 2 brain function to change mood, perception or consciousness; QA - Quality Assurance; Rehabilitation - treatment for recovery from injury or disease; RN - Registered Nurse; RP - responsible party; SBAR (Situation - Background - Assessment - Recommendation) - technique to improve communication; Skin turgor - how fast skin returns to normal when pinched, non-tenting is when skin returns quickly and is a sign of being hydrated; Supervision - oversight, encouragement or cueing; SW - Social Worker; UM - Unit Manager.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		9/16/19

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F 580	Continued From page 3 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R6) out of three sampled residents, the facility failed to notify the responsible party (RP) when an antipsychotic medication was initiated. Findings include: Review of R6's medical record revealed:	F 580	The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all the requirements as of the completion date specified in the plan of correction for the	

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F 580	Continued From page 4 6/6/19 - R6 was admitted for rehabilitation after a hospitalization with multiple diagnoses including dementia. 6/11/19 - An antipsychotic medication (Seroquel) was ordered to start at bedtime for delusions and physical violence. There was no evidence in the record that R6's RP (F1) was informed and provided informed consent. 7/23/19 (11:05 AM) - During an interview, E7 (RN, UM) when asked where the surveyor would find that F1 (RP) was informed of medication changes, E7 said it was "written in a note." E7 searched and found a note that the orders written on 6/13/19 were discussed with F1. There was no evidence that F1 was informed that an antipsychotic was ordered on 6/11/19 in a note or a consent. 7/23/19 - During an interview with F1 (RP) between 5:34 PM - 6:35 PM, F1 stated the first time he/she became aware that R6 was on Seroquel was at the care plan meeting on 6/28/19. "That was the first I heard about it." F1 expressed concern over the medication since "I was told that people with dementia should not be on that medicine." Findings were reviewed with E1 (NHA), E2 (DON) and E5 (QA RN) on 7/24/19 during the exit conference beginning at 1:50 PM.	F 580	noted deficiency. Therefore, the facility requests that this plan of correction serve as it's allegation of substantial compliance with all the requirements as of 9/16/19. A. R6 was discharged. No further correction needed. B. All residents medical records will be reviewed by nursing management staff/designee to ensure residents with new orders of anti-psychotic medication within the last month have documented resident/ family notification. Resident and family notification will be completed if no proof/documentation can be found. C. The root cause of the problem is that Licensed Staff were not consistently notifying the resident/family of new medication ordered. All Licensed Nurse and all new hires will be in-serviced by Staff Development regarding resident/family notification of new orders for anti-psychotic medication. D. Daily audit by nursing management staff of all new anti-psychotic orders will be conducted to ensure that proof of resident/family notification of the new order is in place until 95% compliance and higher is achieved x 3 consecutive evaluations. Following will be a weekly audit until 95% or higher is consistently achieved x 4 evaluations, then monthly for the next quarter or until 95% or higher is consistently achieved x 3 evaluations.. In	

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F 580	Continued From page 5	F 580	an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy	F 585		9/16/19

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F 585	Continued From page 6 to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by	F 585		

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F 585	Continued From page 7 anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that the facility failed to identify concerns for one (R6) out of one resident sampled for grievances. This failure resulted in the issues not being addressed. Findings include: The facility Grievance policy (revised 11/28/16) included: "It is the policy of this facility to assist residents, their representatives, other interested family members, or advocates in filing grievances or complaints when such requests are made...It is	F 585	A. R6 was discharged. No further correction needed. B. All resident s care plan meeting notes in the last two weeks will be reviewed by nursing management staff/designee to ensure that there are no outstanding grievances unresolved. All management and administrative staff will be interviewed by the Assistant Administrator/Designee for any outstanding concerns voiced about by	

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F 585	Continued From page 8 the policy that the disposition of all grievances and/or complaints be recorded on our facility's Grievance and Complaint Log ...Should a staff member overhear, or be the recipient of a complaint voiced by a resident, his/her representative, or other interested family member concerning the resident's medical care, treatment, food, clothing, behavior of other residents, etc, the staff member should encourage and assist the resident or person acting on the resident's behalf; to file a written concern with the facility". 7/23/19 - During an interview with F1 (R6's RP - responsible party), between 5:34 PM - 6:35 PM, F1 expressed concern that he/she "never saw a doctor" during R6's stay at the facility and "did not know what was going on" with R6. When asked if he/she ever informed a staff person of the desire to see the doctor, F1 explained that he/she informed E11 (Concierge). F1 added that "I tried to be cooperative and not complain a lot, but act as a liaison...I was afraid they would (retaliate)." F1 explained "[he/she] was told at the team meeting on 6/28/19 that they [facility] needed to arrange for [E18 (Psychiatric NP)] to see [R6]." When the surveyor explained that E19 (Psychologist) saw R6 on June 7 and E18 evaluated R6 on June 11, F1 stated, "I was never informed....no one told me." F1 said he/she visited every day before work around 6:15 AM and again after work arriving anywhere between 5:00 PM and 7:45 PM. F1 would sometimes be able to visit at lunch time, too. Review of the grievance log revealed no entries regarding F1's (RP) concerns about R6. 7/24/19 (8:19 AM) - During an interview, E11	F 585	resident/family members. E12 no longer works in the facility. E11 will be educated regarding Policy and Procedure of Grievance resolution process. C. The root cause of the deficient practice was family s verbalization of concerns did not reach appropriate staff to elevate those concerns into a grievance thereby a resolution was not met. All staff and new hires will be in-serviced regarding the Policy and Procedure of Grievance Resolution process. Emphasis of the education will be on the steps each staff has to go through when not sure or continued barrier is met when a resident or family member verbalized concerns. D. Daily, during morning meeting grievance officer will ask management staff of any new grievance/concerns. Daily audit by social services department will be conducted to ensure grievances are handled appropriately as per the Policy and Procedure until 95% compliance and higher are achieved x 3 consecutive evaluations. Following will be a weekly audit until 95% or higher is consistently achieved x 4 evaluations, then monthly for the next quarter or until 95% or higher is consistently achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to	

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F 585	Continued From page 9 (Concierge) confirmed that F1 (RP) had expressed "concern about lack of communication on our part." When asked what E11 did with the information, E11 said he/she informed E12 (former acting SW Director). E11 added that when F1 later "informed me [E12] did not return the call, I told [F1] that [E12] was not here and I informed [E13, SW] and [E14, SW]." E11 stated that he/she would "search emails to locate the notification" and provide a copy to the surveyor. 7/24/19 (8:27 AM) - During an interview, E4 (Assistant Administrator), who was located in the social work office, said he/she would check into F1's (RP) complaint and grievance log entry. E4 indicated he/she would have to call E12 (former acting SW Director) "to see if [E12] did a form or documented it somewhere else." No additional information was provided to the surveyor during the survey. 7/24/19 (10:05 AM) - E11 (Concierge) provided a copy of the email and attached a text conversation that was sent on 6/22/19 at 8:22 AM to E7 (RN, UM), E12 (former acting SW Director), E13 (SW) and cc (carbon copy) to E3 (ADON). F1's (RP) text stated, "I still have not had a team meeting or seen a dr (doctor). I am clueless as to what is going on. I am very upset." E11 responded that he/she would bring up F1's concerns "when I meet with everyone at 9 [AM]." In response to inquiry about when F1 would be at the facility visiting, F1 wrote "I will be there tonight at 5 [PM]. I am there every morning at 6:15 [AM]. I also came when requested by PT to help with therapy. I am easily reachable by text." The facility failed to identify F1's issues as a grievance, resulting in the lack of an investigation	F 585	review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.	

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F 585	Continued From page 10 to address the concerns. Findings were reviewed with E1 (NHA), E2 (DON) and E5 (QA RN) on 7/24/19 during the exit conference beginning at 1:50 PM.	F 585		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for two (R8 and R9) out of three sampled residents for review of abuse, the facility failed to ensure freedom from resident to resident sexual abuse and for one (R2) out of three sampled residents for review abuse the facility failed to ensure freedom from staff to resident verbal abuse. Findings include: 1. The facility policy entitled "Abuse of Residents", last updated on 3/7/18, indicated that each resident has the right to be free from	F 600	1. A. R5 is currently on a modified 1:1 schedule with staff while up and awake. R5 is to be in close proximity with a staff member who is on a seating schedule for resident supervision in the common area. E15 was in-serviced by Staff Development on July 16, 2019 B. All residents medical records will be reviewed by nursing management staff/designee to ensure residents with	9/16/19

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F 600	Continued From page 11 abuse...and that residents shall not be subjected to abuse by anyone including but not limited to staff, other resident... The policy contained the following content: Sexual: Abuse as non-consensual sexual contact of any type with a resident. Including but not limited to sexual harassment, sexual coercion or sexual assault. Prevention: Specific incidents are reviewed to identify areas for improvement and needed policy changes or interventions to be implemented. This includes but is not limited to specific environmental, operational, staffing issues, educational and supervisory issues. The resident's assessment and care plan, as well as staff supervision with on-going monitoring are used to identify residents with at risk behaviors. Identification: Any staff observing suspected abuse shall remove the resident from danger and notify the nurse immediately. A person shall not knowingly fail to report an incident of mistreatment and other offense; screen reports or withhold information to reporting agencies. The following information was reviewed in clinical records and facility documents: 4/8/19 - An Admission MDS assessment documented R5 as severely cognitively impaired with a BIMS of 2. 4/9/19 - A care plan was initiated with regard to R5's use of psychotropic medications related to physical aggression as evidenced by grabbing, swinging, hitting at staff and others to include an intervention of "staff to monitor behavior daily. Observe for increases in behavior ... or if behavior is interfering with ...safety of patient or others ..."	F 600	inappropriate sexual behaviors are care planned appropriately and special care instructions communicated to other departments to avoid similar incident with R5. C. The root cause of the deficient practice after investigation was identified as the other department was not aware of special care instructions of the resident being monitored. All activities aide were in-serviced by Staff Development on July 16, 2019. Activities Department will be provided with CERNER (profile history information access) to ensure they have access to resident s special care needs/instructions. All staff/new hires will be in-serviced regarding appropriate communication with nursing staff to ensure residents requiring supervision/special care instruction are communicated effectively. D. Daily random audit by management/administrative staff/Designee by observation and interview with different departments will be conducted to ensure appropriate communication with departments is in place regarding plan of care of residents needing supervision/special care until 95% compliance or higher is achieved x 3 consecutive evaluations. Following will be a weekly audit until 95% or higher is achieved x 4, then monthly for the next quarter or when 95% or higher is consistently achieved by 3 evaluations. In	

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F 600	Continued From page 12 5/19/19 - A quarterly MDS confirmed that R5 has a BIMS of 5, reflecting severe cognitive impairment. 5/28/19 - A computerized note indicated that R5 continued to "touch/grab female staff members backside/buttocks. [R5] educated that this is not appropriate behavior. Education ineffective; [R5] continued to still touch female staff inappropriately." 5/29/19 - A care plan was initiated for R5 regarding "inappropriate touching, grabbing of staff/resident's buttocks" with no goal identified. Incident #1 6/4/19 11:02 PM - A computerized note asserted that "Resident" R5 grabbed another resident's (R9's) breast during the shift. He/she said he/she didn't know what he/she was doing when asked why he/she did that. R5 was told that he/she "couldn't touch [him/her] or other residents in that manner ..." the nursing supervisor on the shift advised staff to put him/her on checks every hour. 6/5/19 - A computerized note stated that R5 had to be redirected from making sexual gestures to staff .... and nursing would continue to monitor. 6/5/19 - A computerized note confirmed that R5 was on a one to one monitoring. 6/5/19 - The facility incident investigation revealed that a police officer spoke with R5 and "[he/she] cannot recall what happened last night nor can [he/she] recall what [he/she did]. [He/she] asked the police officer, I did that?.... Officer informed	F 600	an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter. 2. A. R2 was interviewed on 7/24/19 and denied E25 shaking him up. R2 confirmed on interview on 5/2/19 by QA Director that R2 recognizes he was guilty and do not want anything done about it. E25 no longer works in the facility. B. Leadership staff/Designee staff will conduct random observation on all units and shifts for any allegation of abuse. C. The root cause of the incident was R2 overhead paged inappropriately despite previous conversation with him that his actions were inappropriate. E25 s reaction to the situation was to confront the resident due to fear of the other resident s in the building misunderstanding the overhead page which could result in injury. The action was observed and interpreted as abusive. All staff and new hires will be in-serviced by Staff Development/Designee on Policy and	

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F 600	Continued From page 13 [him/her] that it is not appropriate for [him/her] touching a man or a woman without consent. [R5] responded, 'I understand'." 6/5/19 - The care plan related to R5's use of psychotropic medications was amended to include an intervention for "frequent monitoring when up and awake; ensure resident is not in close proximity with a female resident." 6/6/19 - A computerized note confirmed that R5 touched a staff member on the buttocks once that shift. 6/6/19 - An email communication from (town name) Police Department (contacted after 6/5/19 incident at the request of R9's spouse) stated, "after extensive conversation (with the deputy Attorney General), we both feel as though we cannot prosecute the case (due to R5's mental capacity); however, it is recommended that safeguards be put in place to prevent [R5] from being able to touch anyone in that manner again ..." 6/7/19 - A computerized note indicated that R5 touched a female staff members buttock. 6/8/19 - A computerized note reflected that R5 touched female staff buttocks two times. 6/10/19 - A follow up report from the facility stated, " ....[R5] (has) a diagnosis including dementia with behavioral disturbance ... BIMS of 3 (indicating severe cognitive impairment) ....Continues to be on monitoring to ensure [he/she] is not in close proximity with any female resident in the unit."	F 600	Procedure on Abuse Prohibition with focus on Verbal Abuse and body language and gestures. D. Daily random audit by leadership staff/Designee of 10% sample of total staff by observation and interview with different department will be conducted to ensure staff is aware of Verbal Abuse and appropriate intervention to follow if observed until 100% compliance is achieved x 3 consecutive evaluations. Following will be a weekly audit x 4, then monthly for the next quarter. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.	

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F 600	Continued From page 14 6/10/19 - The care plan for "inappropriate touching, grabbing of staff/resident's buttocks" was modified to include an intervention to "Ensure [R5] is not within close proximity with female residents; frequent monitoring." 6/11/19 - A computerized note indicated that R5 had one episode of inappropriate touching where he/she grabbed an aide's buttocks and that nursing will continue to monitor. 6/13/19 - A computerized note stated, "The therapist stated that [R5] is inappropriate: '[he/she] was being naughty and [he/she] tried to touch [his/her] breast and kiss [him/her]'." 7/12/19 - A nurse practitioner note detailed that "RN noted that [R5] is having ongoing increased combative behaviors/touching staff members ... [He/She] is a poor historian secondary to ... ongoing dementia ... Plan includes maintain patient safety/safety of other residents. Continue to monitor." Incident #2 7/13/19 11:49 PM - A facility's computerized note revealed, "[R5] had placed [his/her] hand into a ... patient's (R8) groin and was rubbing it vigorously. Both patients were immediately separated ... and assessed .... Victim appeared to have not suffered any trauma and was not able to provide a description. [R8] also had no description or memory of event. Writer informed [R8] of inappropriateness of [R5's] actions and to please not touch other patients. [R5] did not voice understanding and said, 'I guess. I don't know'. On call provider informed of incident and asked for any further orders for either patient. Only order	F 600		

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F 600	Continued From page 15 at this time was to place [R5] on a one to one monitoring till further evaluation of this patient. Writer called [R5's] representative to advise of incident and [he/she] expressed understanding that this was a continuing behavior for [R5]." 7/13/19 - A written statement by E17 (LPN) affirmed that he/she was "checking on residents. Looked into Namaste room noted [R5] with hand between [R8's] legs rubbing [him/her]. I ran into room to stop the behavior and move [R5] away from [R8]. While taking [R5] out of the room, [R5] began laughing about the situation." 7/14/19 - A written statement made by E15 (Activities Aide) confirmed that "I was not aware that [R5] could not be alone and in close proximity to female residents." 7/17/19 - A follow up report from the facility indicated the following: "Resident has dementia and is cognitively unable to decipher appropriate vs inappropriate touching. Resident was placed on one to one supervision while [R5] is up and awake. Upon completion of the investigation, it was confirmed that [R5] did in fact touch [R8], but [R8] was not negatively affected by this incident. Upon questioning, the [R8] does not recall the incident or have any change in mood or affect, secondary to cognitive deficits and past cerebral infarct (stroke). [R5] is maintained on one to one monitoring while up and awake, as well as when near female resident. No further incidents have occurred." 7/18/19 - The care plan related to R5's use of psychotropic medication was modified to reflect an intervention for "modified 1:1 (one to one monitoring); [R5] will be encouraged to sit next to	F 600		

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F 600	Continued From page 16 the staff in charge of seating schedule ..." 7/18/19 - An entry in the CNA task log stated, "1:1 (one to one monitoring) with seating schedule when [R5] is awake" and "Frequent monitoring when up and awake; ensure [R5] is not in close proximity with a female resident." 7/24/19 at approximately 8:27 AM - An interview with E16 (RN) revealed that report is given to CNA's after the nurses give report in order to inform staff of relevant resident behaviors. Nurses rely on the Front Hall report sheet, which documents information, such as behaviors (R5's entry reflects sexual behaviors), blood glucose sugar levels, fall risk, etc "If there is something new, it is written in" and then added to the Front Hall Report that is printed from the facility's computer system. E16 stated that CNA's have their own reporting system. He/she further stated that a CNA might not be aware of certain behaviors if an aide were pulled from another unit, if someone arrived late or if reporting staff was assisting residents. Although a plan of care was in place to monitor R5, the facility failed to ensure that the plan of care was followed, such that R8 and R9 were sexually abused by R5. 2. The facility policy entitled "Abuse of Residents" last updated on 3/7/18, indicated that each resident has the right to be free from abuse...and that residents shall not be subjected to abuse by anyone including but not limited to staff, other resident... The policy contained the following content: Abuse: Refers to the willful infliction of injury ... intimidation or punishment resulting in physical	F 600		

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harm, pain or mental anguish. It includes verbal abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.
Verbal: Refers to any use of oral, written or gestured language that includes disparaging and derogatory terms to resident or their families, or within hearing distance to describe residents, regardless of their age, ability to comprehend or disability. Examples of verbal abuse include, but are not limited to: threats of harm, saying things to frighten a resident ....

The following information was reviewed in clinical records and facility documents:

2/26/18 - A care plan identified "Socially inappropriate verbal behavior as evidenced (by ordering staff and residents to do "whatever I say"), yelling at staff along with inappropriate comments made to other residents related to need for attention, unknown etiology. Interventions include: "Remain calm and avoid angry reactions if [R2] exhibits behavior".

12/30/18 - A computerized note indicated that "[R2] was noted behind nursing station by staff member walking by and [he/she] was on the phone and was heard over the intercom saying inappropriate things. [He/She] was re-directed back to room [he/she] later came back out [his/her] room and got on the intercom again. [He/She] was educated by nurse that [his/her] behaviors was (sic) very inappropriate. Supervisor notified and also educated [him/her]."

2/7/19 - A care plan identified "attention seeking behaviors as evidenced by making intercom calls

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in the facility with a goal that [R2] will not use facility intercom system for personal use. Interventions include: 1) psychiatric referral as appropriate; 2) Will provide education to [R2] regarding appropriate social behaviors; 3) Will review resident's rights with [R2]."

4/11/19 - The Ombudsman filed a complaint on behalf of an anonymous complainant reporting that on April 1, 2019 (April Fool's Day), R2 used the intercom at his/her unit's nurses station and stated that the facility had been sold, such that all residents would need to leave the facility.

4/25/19 - A written statement from E25 (former NHA) concerning "conversation" with R2 on 4/1/19 reflected that "[he/she] was concerned for residents' safety - especially those who cannot move themselves. [He/she] wrote that if these residents heard that the police were coming, they might try to get up without assistance. [He/She] was fearful of what would happen. I spoke to [R2] in a stern voice questioning on why [he/she] was once again using the intercom for inappropriate messaging. I further explained about how these inappropriate messages are very frightening and disturbing to some residents ... who would get up without assistance to get ready to leave .... In previous conversations with [R2], I had told [him/her] if [he/she] continued with these disturbing behaviors [his/her] social worker would need to work with [him/her] to find alternative living arrangements. I do not recall exactly, but I may have reminded [R2] of that fact in this conversation." Later, E25 (former NHA) told "[R2] if [he/she] had perceived I was upset earlier, I apologize. I was upset with the circumstance and [his/her] behavior, not [him/her]. [He/she] acknowledged [he/she] was

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wrong, accepted my apology and we parted".

4/26/19 - A quarterly MDS assessment confirmed that R2 had a BIMS of 14 (cognitively intact).

7/23/19 11:00 AM - During an interview with E1 (NHA), he/she confirmed that he/she and E25 (former NHA) talked about the 4/1/19 incident, but that they did not believe it was abuse based on their conversation. E25 (former NHA) was hurt by the account of the incident as he/she always thought that he/she and R2 had a good rapport and, further, that the description of the alleged incident was inaccurate. E1 did not hear of the incident until several weeks later.

7/24/19 8:15 AM - During an interview, A3 (anonymous witness) confirmed that he/she recalled the incident that happened on 4/1/19. A3 stated that E25 (former NHA) came up to the unit after R2 made the announcement. E25 spun R2 around in the wheelchair, had his/her finger in R2's face, was loud and very upset. He/She told R2 that what he/she did wasn't funny and that it is not fair to other residents. He/She then stopped and turned around in the hallway. A3 reported that there were residents and family members in the hallway when this happened. A3 stated, "It shouldn't have happened."

7/24/19 approximately 8:45 AM - During an interview with R2, he/she stated that "E25 (former NHA) didn't shake me up. I did something I shouldn't have. [He/She] shook up other people. People take things different. [He/She] was doing discipline. I don't have anything against [him/her]. I shouldn't be saying this but [he/she] was getting ready to retire and I didn't want to ruin [his/her] retirement. [He/She] was doing discipline and

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F 600	Continued From page 20 shouldn't be punished. [He/She] did [his/her] job. [He/She] scared me a little, but [he/she] should be doing just as [he/she] done (sic)." 7/24/19 approximately 9:08 AM - During an interview, A2 (anonymous witness) confirmed that he/she recalled the incident that happened on 4/1/19. He/She stated that E25 (former NHA) was angry, his/her face was red and their finger was pointing in R2's face. A2 stated that E25 was mad at R2 for having made the announcement over the intercom and was going to call the social worker to have R2 moved. 7/24/19 11:19 AM - During an interview with A1 (anonymous witness), he/she stated that R2 "gets on the intercom and says things". A1 recalled the incident and further stated that E25 (former NHA) came to the desk where R2 was attempting to leave. E25 was mad, spun him/her around, with his/her finger in R2's face. E25 told R2 that he/she needs to call your social worker and find someplace else to go. E25 then realized that there were other people around, including the family member of a now deceased resident, two staff and two people A1 stated he/she did not recognize. A1 stated that he/she "felt some type of way" and believes R2 did too, "like [he/she] was embarrassed". A1 stated that R2 would have fallen out of the wheelchair if he/she were smaller by the way E25 "whisked" the wheelchair around. A1 stated that R2 was embarrassed and afraid to go to the hospital the next day because he/she was worried he/she would not be let back in the facility with nowhere to go. A1 stated that he/she felt this represented verbal abuse based on the way he/she looked and acted. A1 stated, "I know abuse when I see it: hands in someone's face and speaking loudly".	F 600		

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F 600	Continued From page 21 The facility failed to ensure R2 was free from verbal abuse and intimidation by E25 (former NHA). These findings were reviewed with E1 (NHA), E2 (DON) and E5 (QA RN) at the exit conference beginning on July 24, 2109 at approximately 2:00 PM.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for one (R2) out of three sampled residents, the facility failed to thoroughly investigate an allegation of abuse by failing to obtain staff statements upon learning of an allegation of	F 610	A. R2 s confirmed statement from interview on 5/2/19 by QA director misled the investigation for allegation of abuse due to resident confirming he did not feel he was abused. E25 no longer works in the facility.	9/16/19

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F 610	Continued From page 22 verbal abuse. Findings include: The facility policy entitled "Abuse of Residents" last updated on 3/7/18, indicated the following: Upon receiving an incident or suspected incident of resident abuse ...., the Administrator/DON/designee will conduct an investigation to include but not limited to the following: Complete designated report form for investigation of abuse, neglect ...; Interview any witnesses to the incident; Interview staff members (on all shifts) having contact with the resident during the period of the alleged incident; ... Review all circumstances surrounding the incident.: 4/11/19 - The Ombudsman filed a complaint on behalf of an anonymous complainant reporting that on April 1, 2019 (April Fool's Day), R2 used the intercom at his/her unit's nurses station and stated that the facility had been sold and that all residents would need to leave the facility. Clinical record review and facility documentation review revealed: 4/25/19 - A written statement from E25 (former NHA) concerning "conversation with R2 on 4/1/19 reflected that [he/she] was concerned for residents' safety. [He/she] wrote that if certain residents heard that the police were coming, they might try to get up without assistance. [He/She] was fearful of what would happen. I spoke to [R2] in a stern voice questioning on why [he/she] was once again using the intercom for inappropriate messaging ... In previous conversations with [R2], I had told [him/her] if	F 610	Staff involved in the investigation of the allegation will be educated regarding allegation of Verbal Abuse investigation component. Completed on 8/21/19. B. All allegations of abuse investigations within the last month will be reviewed by DON/Designee to ensure appropriate statements and all components of investigation were completed to analyze the incident appropriately. C. The root cause of the deficient practice was the investigation components were not completed to analyze the incident appropriately. All management staff/new hires will be in-serviced by Staff Development/Designee regarding appropriate documentations/statements and all other components are gathered when investigating an allegation of abuse. D. Daily audit by DON/Designee of all allegations of abuse investigations will be conducted to ensure appropriate documentation/statements were gathered until a 100% compliance is achieved x 3 consecutive days. Following will be a weekly audit until a 100% compliance is achieved x 4, then monthly for the next quarter or until a 100% compliance is achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to	

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F 610	Continued From page 23 [he/she] continued with these disturbing behaviors, [his/her] social worker would need to work with [him/her] to find alternative living arrangements. I do not recall exactly, but I may have reminded [R2] of that fact in this conversation. Later, (NHA) told [R2] if [he/she] had perceived I was upset earlier, I apologize. I was upset with the circumstance and [his/her] behavior, not [him/her]. [He/she] acknowledged [he/she] was wrong, accepted my apology and we parted". 4/26/19 - A quarterly MDS assessment confirmed that R2 had a BIMS of 14 (cognitively intact). 7/23/19 - Review of the facility incident investigation revealed that it contained the following statements: interview with R2 by E5 (QA Nurse), a written statement by E3 (ADON), an email from E22 (former Social Services Director), an email from E23 (Human Resources), a handwritten statement from E24 (Maintenance), and a handwritten statement from E25 (former NHA). E3, E22, E23 and E24 did not witness the incident. The investigation file lacked evidence of any staff interviews of those employees working on that particular unit during the time the incident occurred. 7/23/19 11:00 AM - During an interview with E1 (NHA), who stated that he/she and E25 (former NHA) talked about the 4/1/19 incident, but that they did not believe the incident was abuse based on their conversation. 7/23/19 - approximately 4:25 PM - An interview with E6 (Unit Manager) confirmed that he/she did not witness the alleged incident on 4/19/19 and nor did any staff report any incident to him/her.	F 610	maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly.	

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F 610	Continued From page 24 7/24/19 8:15 AM - During an interview, A3 (anonymous staff member) confirmed that he/she recalled the incident that happened on 4/1/19. A3 stated that E25 (former NHA) came up to the unit after R2 made the announcement. E25 spun R2 around in wheelchair, had his/her finger in R2's face, was loud and very upset. He/She told R2 that what he/she did wasn't funny and that it is not fair to other residents. He/She then stopped and turned around in the hallway. A3 reported that there were residents and family members in the hallway when this happened. A3 stated, "It shouldn't have happened." 7/24/19 approximately 8:45 AM - During an interview with R2, he/she stated that "E25 (former NHA) didn't shake me up. I did something I shouldn't have. [He/She] shook up other people. People take things different. [He/She] was doing discipline. I don't have anything against [him/her]. I shouldn't be saying this but [he/she] was getting ready to retire and I didn't want to ruin [his/her] retirement. [He/She] was doing discipline and shouldn't be punished. [He/She] did [his/her] job. [He/She] scared me a little, but [he/she] should be doing just as [he/she] done (sic)." 7/24/19 approximately 9:08 AM - During an interview, A2 (anonymous staff member) confirmed that he/she recalled the incident that happened on 4/1/19. He/She stated that E25 (former NHA) was angry, his/her face was red and E25's finger was pointing in R2's face. A2 stated that E25 (former NHA) was mad at R2 for having made the announcement over the intercom and was going to call the social worker to have R2 moved.	F 610		

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F 610	Continued From page 25 7/24/19 11:19 AM - During an interview with A1 (anonymous staff member), he/she stated that R2 "gets on the intercom and says things". A1 recalled the incident and, further, that E25 (former NHA) came to the desk where R2 was attempting to leave. E25 was mad, spun him/her around, with his/her finger in R2's face. E25 told R2 that he/she needs to call your social worker and find someplace else to go. E25 then realized that there were other people around, including the family member of a now deceased resident, two staff and two people A1 stated he/she did not recognize. A1 stated that he/she "felt some type of way" and believed R2 did too, "like [he/she] was embarrassed". A1 stated that R2 would have fallen out of the wheelchair if he/she were smaller by the way E25 "whisked" the wheelchair around. A1 stated that R2 was embarrassed and afraid to go to the hospital the next day because he/she was worried he/she would not be let back in the facility with nowhere to go. A1 stated that he/she felt this represented verbal abuse based on the way he/she looked and acted. A1 stated, "I know abuse when I see it: hands in someone's face and speaking loudly". 7/24/19 11:52 AM - An interview with E5 (QA Nurse) confirmed that no employee statements were taken from the other employees working on that unit that day. Based on the foregoing, it was determined that the facility failed to undertake a complete investigation in that no staff from the unit in question were interviewed after the facility was made aware of the incident on April 1, 2019. Findings were reviewed with E1 (NHA), E2 (DON) and E5 (QA Nurse) on 7/24/19 at the exit	F 610		

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F 610	Continued From page 26 conference beginning at 1:50 PM.	F 610		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide sufficient fluids to maintain adequate hydration for one (R6) out of three residents sampled for neglect. Findings include: Review of R6's clinical record revealed: 6/5/19 - Hospital lab tests showed normal kidney function: BUN 19 (range 9-20) and creatinine 0.79 (range 0.66-1.25). Elevated WBC (cells that	F 692	A. R6 was discharged. No further correction needed. B. All other residents with an order for fluid monitoring will be reviewed to ensure fluid goal is specified and total fluid volume is monitored daily. All active residents with orders for Lasix for edema will be reviewed to ensure a re-evaluation for use is completed.	9/16/19

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F 692	Continued From page 27 fight infection) at 11.7 (range 3.7 - 8.9). 6/6/19 - R6 was admitted to the facility after hospitalization with multiple diagnoses including dementia. R6's weight was 198.8 pounds on admission. 6/6/19 - R6's physicians' orders included a regular, low fiber diet...with fortified (high calorie and protein) pudding at lunch and dinner. 6/6/19 (11:57 PM) - The admission skilled nursing note documented that R6 had swelling (edema) in both legs. "Urine [was] yellow...Skin turgor [was] non-tenting." 6/8/19 - The Nutrition Assessment identified that R6 had swelling in both legs and his/her meal intake was described as "Fair." R6 was able to feed him/herself independently after setup without swallowing problems. E10 (Dietician) calculated R6's fluid requirements to be 2,004 mL daily and indicated that R6 took fluids "well." E10 recommended to "encourage fluids every shift" and would "monitor intake (how much R6 ate and drank), weights(wts), labs, trends for need to adjust nutritional interventions as needed." 6/8/19 - A care plan was developed for alteration in nutritional status related to deceased oral intake, weight loss and expected weight variances related to edema. Interventions included: observe for, and report, signs and symptoms of fluid imbalances such as labored breathing, increased lethargy, shortness of breath, decreased skin turgor, dry oral membranes; observe skin, labs and hydration status as needed; provide prescribed diet, supplement, fortified foods and monitor during	F 692	C. The root cause of the deficient practice was resident was encouraged with fluids as ordered on both occasions but no fluid goal was specified to ensure recommended fluids daily is consumed. The total fluid volume was not monitored daily to ensure that fluid goal is met or unmet based on recommended fluid requirement. There was no re-evaluation of the need for Lasix after edema was resolved. Residents identified by Providers as high risk due to decreased hydration based on laboratory result will have fluid intake monitoring ordered. This will include extra fluid goals to offer resident to meet fluid requirement recommendation. Daily fluid intake will be totaled by nursing staff to evaluate if resident is meeting their fluid goal based on recommended requirement. All Licensed staff, Dietician, Providers and new hires will be in-serviced by Staff Development/Designee to ensure resident with fluid monitoring ordered will have fluid requirement goal indicated and daily fluid intake is totaled to ensure fluid requirement as per recommendation is met. All Medical Providers will be in-serviced by the Medical Director regarding appropriate re-evaluation of Lasix use for residents with edema.	

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F 692	Continued From page 28 and between meals for consumption (amount taken); record percent of each meal and / or supplement consumed; record weight and notify physician, patient, family or significant other of any significant change; Refer to dietitian for evaluation / recommendations; and review lab values. Notify physician of abnormal values as needed. 6/10/19 - R6's eMAR showed the initiation of "Offer additional 240 mL fluid po (by mouth) q (every) shift." This was scheduled for the day shift, evening shift and night shift, or three times a day. 6/12/19 - R6's weight increased to 205.6 pounds (indicating R6's body was retaining fluid). 6/13/19 - R6's physicians' orders included Lasix (diuretic medication to get rid of excess fluid in the body). 6/15/19 - A care plan problem was initiated for R6 for being on diuretic. Interventions included; may cause dizziness, postural hypotension, fatigue...observe for possible side effects and report pertinent lab results to physician. 6/17/19 - R6's laboratory tests revealed normal kidney function: BUN 15 (range 9-20) and creatinine 0.9 (range 0.66-1.25). WBC slightly improved, but still elevated at 11.3. 6/20/19 - E10's (Dietician) note documented that "Intake at meals 20-38%, taking fortified foods 50-100% most days. Fluids encouraged, taken well. Feeds self after setup...Weekly wt (weight) this week refused...Wt last week 205.6# (pounds)...BLE (both legs) edema (swelling).	F 692	D. Daily audit by nursing management staff of residents with an order for fluid monitoring will be conducted to ensure fluid goal is specified and daily total of fluid volume is monitored to ensure fluid requirement as per recommendation until a 95% compliance or higher is achieved x 3 consecutive evaluations. Following will be a weekly audit until a 95% or higher compliance is consistently achieved x 4 evaluations, then monthly for the next quarter or until 95% or higher is consistently achieved x 3 evaluations. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter. Daily audit by nursing management staff of residents with new orders of Lasix will be conducted to ensure that Lasix re-evaluation for edema use is in place when the medication was ordered until a 100% compliance is achieved x 3 consecutive evaluations. Following will be a weekly audit until a 100% compliance is consistently achieved x 4, then monthly for the next quarter or until a 100% compliance is consistently achieved x 3 evaluations.	

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F 692	Continued From page 29 Labs 6/10...BUN 10 and creatinine 0.7...no s/s (signs and symptoms) dehydration...Continues on Lasix." 6/27/19 - E10 (Dietician) note identified "Current weekly wts: 169.4# - 176.8#...Intakes at meals 13-30% with fluids encouraged, taken fair - well...Labs 6/17... no s/s dehydration. MD (physician) aware of wt variances r/t (related to) fluid changes. Will recommend to follow wts daily x (for) 7 days and start 2 cal supplement (high calorie drink) due to decreased po intakes." 6/27/19 - R6's physicians' orders included 2 cal (120 mL) to be given by mouth three times a day. 6/28/19 - Blood test results showed R6's kidney function was now impaired (abnormal): BUN 57 (normal 9 - 20) and creatinine 2.90 (normal 0.66 - 1.25). Potassium was elevated at 6.0 (normal 3.5 - 5.1). A handwritten notation by the nurse on the bottom of the lab results timed at 5:45 PM included that E20 (Physician) notified. Orders included "encourage fluids every shift, discontinue potassium (given orally once a day), blood test in the morning and on Monday [July 1]." There was no change in the amount / frequency of additional fluids scheduled every shift (originally ordered 6/10/19) nor a specific intake goal. 6/28/19 (6:18 PM) - A nurse's note documented that labs were done that morning due to R6's "recent increased confusion." Urine with "2+ blood" and to document mL's consumed when encouraging fluids every shift.	F 692		

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F 692	Continued From page 30 Again, no goal for fluid intake was established. 6/29/19 - Blood test results included BUN unchanged at 57 and creatinine with some improvement at 2.20. Potassium also improved, but still was slightly elevated at 5.6. A handwritten notation (untimed) by the nurse that E21 (PA) notified of the test results and no new orders, continue encouraging fluids every shift and recheck lab tests on Monday as originally written by E20 (Physician). There was no change in the amount / frequency of additional fluids scheduled every shift (originally ordered 6/10/19) nor a specific intake goal. June - July 2019 - Review of R6's CNA documentation, eMAR, eTAR and nursing notes revealed R6's meal and fluid intake varied and ultimately declined: - June 7-14: meal average 47% (range 0-100% with 2 meal refusals out of 21 meals - 9.5%); fluid average 1,677 mL (range 1,200 - 1,940 mL). - June 15-21: meal average 15.5% (range 0-100% with 11 meal refusals out of 21 meals - 52.3%); fluid average 1,407 mL (range 1,200 - 2,070 mL). - June 22-28: meal average 16.1% (range 0-75% with 11 meal refusals out of 21 meals - 52%); fluid average 1,213 mL (range 739 - 1,680 mL). - June 29-July 3: meal average 6.7% (range 0-25% with 11 meal refusals out of 15 meals - 73.3%); fluid average 1,128 mL (range 760 - 1,620 mL). There was no evidence that the facility was monitoring R6's fluid totals daily to determine if the resident was meeting the 2,004 mL daily	F 692		

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F 692	Continued From page 31 intake calculated by the dietician. 7/1/19 - E9's (NP) note documented that R6 was seen for "increased behaviors - aggitation (sic)/ resistive of care/ combative." R6 "did allow provider to perform exam"...labs were reviewed... WBC 11.9 (elevated)..."appetite is ok... There has been a progressive wt (weight) loss... is on a diuretic at this time." Physical exam did not include the assessment of edema. Assessment included leukocytosis (elevated WBC) and obtain a urine culture to determine if an infection was causing the elevated WBC. There was no mention about the other abnormal labs from June 27 or 28 showing impaired kidney function nor the evaluation of the need for Lasix. 7/2/19 - E9's (NP) note documented the reason for the visit was "ongoing elevating WBC count. Some increased cough / SOB (shortness of breath) reported. Renal functions climbing." R6's WBC was 14.5 and urine culture "returned with no growth" (was normal)...(R6) "had some scattered rhoci (sic) (rhonchi - abnormal lung sounds)...renal functions continue to decline...66 / 2.30 (BUN and creatinine)...po (oral) intake/fluid intake is poor- ongoing need to encourage [him/her]...refuses a lot of [his/her] care / difficult to redirect at times...meds (medications) rev (reviewed)." Assessment included "Acute bronchitis" - obtain STAT chest x-ray. "Leukocytosis"- urine negative, rule out pneumonia. "AKI (acute kidney injury) - ongoing worsening renal functions - medications reviewed, increase oral fluid hydrations, check blood test in the morning, if no improvement will start (an) IV in the morning."	F 692		

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F 692	Continued From page 32 7/3/19 - E9's (NP) note documented that R6 was "lethargic and appears ill...no fever have been reported"...labs reviewed..."showing an ongoing worsening of renal functions in comparison to prev (previous)...PO intake is poor / refusing to eat (and) drink...WBC remains elevated - so far unable to detect where [R6's] infection is coming from....VS / BP's (vital signs / blood pressures) are stable at this time...CXR (chest x-ray) returned negative for any acute findings." Labs from today BUN 72, creatinine 2.7 and WBC 13. Assessment included "Change in mental status...renal functions are worse... AKI... Leukocytosis... Plan included to give IV bolus of normal saline then administer [name of other IV fluids] at 150 mL per hour. Call IV team now for line placement - for now put in a peripheral and wrap it up so he/she doesn't pull it out...Monitor BP's... IF continues to decline / condition worsens - send to ER STAT. Any changes in mentation / unresponsiveness / fever send to ER. Call and update provider with condition / if responding to IV fluids." 7/3/19 (6:30 PM) - A nurses note documented that R6 "became unresponsive after getting [him/her] out of bed, color pale, lungs clear, respirations shallow and unlabored...responds to painful stimuli...(spouse) in facility at time and will meet at the [emergency department]... transferred to [name of hospital] for further evaluation." 7/3/19 - Hospital Admission History and Physical documented that F1 (RP) reported that R6 "has not been eating over the last week or so hardly taking any fluids whatsoever... [R6] looks clearly dehydrated dry mucous membranes... straight catheterization in the emergency room (to empty	F 692		

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F 692	Continued From page 33 the bladder) produced only 50 mL urine...[F1] tells me that [R6] is coming around closer to [his/her] baseline with 2 liters of IV fluid having been given in the emergency department." Admission problem listed the first problem as "acute renal failure...is significantly dehydrated, and volume will be replaced slowly but carefully." 7/23/19 (1140 AM) - During an interview E9 (NP) stated that F1 (RP) "wanted to manage here. When [R6's] BUN was 66 is when we started trying to figure out something else besides po fluids." E9 acknowledged that "[R6] refused the IV... [F1] had trouble making decisions." When asked how it was determined that R6's 'appetite was ok' (from 7/1/19 note), E9 stated that he/she "talked to CNAs" about appetite and meal intake. After the surveyor showed CNA documentation of meal intake with mainly 0 recorded, E9 stated, "When I saw [R6] [he/she] was eating. [R9] would drink anything you would give [him/her] initially." E9 added that "[R6] was verbally abusive toward [F1] and eventually [F1] stopped coming." 7/23/19 (5:34 PM - 6:35 PM) - During an interview F1 (RP) stated that he/she would "visit every day, twice a day - before work around 6:15 AM, after work (anywhere between 5:00 PM and 7:45 PM), and sometimes at lunch...[F1] kept notes in a notebook and informed the surveyor on June 13 [R6] drank 3 milkshakes provided by the family and [R6] knew family members. [R6] was disoriented on June 15 and was still eating on June 17. [F2 (F1's sibling)] would spend most days at the facility. There were times when staff would leave the cup of supplement and [R6] would not drink it. If [R6] would say 'no' when meals were delivered, no one encouraged [R6] to eat, they just left. There were times when visiting	F 692		

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	085037	A. BUILDING _____ B. WING _____	C 07/24/2019

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F 692	Continued From page 34 after work [R6's] meal tray was on the table with the lids still on." When reviewing the events before R6 was sent to the hospital, F1 explained that "a nurse came from another section to get the IV, but by that time, they had to call 911." 7/24/19 (9:40 AM - 9:54 AM) - During an interview with E23 (Medical Director) and E2 (DON), E23 stated that "[R6's] mental status was challenging. We were trying to change [R6's] behavior in hopes [R6] would eat better." While reviewing a chronological listing of kidney function lab tests written by the surveyor, E23 indicated that "from a medical standpoint, when the BUN was in the 50's, residents would not be sent to the hospital. Maybe in the 60's (send to hospital), but the usual treatment is to increase fluids." When E2 stated that "[R6] was receiving extra fluids" the surveyor pointed out that the three times a day fluids given by the nurse had been ordered from early in R6's stay and the frequency / amount was never changed after R6's kidney function declined. E2 added that there was an order to encourage fluids each shift and document mLs. When the surveyor expressed concern in that there was no goal (amount) identified for pushing fluids, to which E23 stated he/she understood the concern of no mL goal. 7/24/19 (12:40 PM) - During a follow-up interview with E9 (NP) to discuss R6's Lasix which had been started after R6 had edema and gained weight, when asked about the use of Lasix use in light of R6's declining renal function. E9 stated he/she "thought I DC'd (discontinued) it... it (Lasix) should have been DC'd." 7/24/19 (4:03 PM to 4:27 PM) - An interview with F2 (F1's sibling) revealed that F2 would be with	F 692		

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F 692	Continued From page 35 R6 most weekdays and varied the times for the visits "... They would deliver meal tray and set on table and leave... did not uncover it or let [R6] know it was there. No encouragement to help [R6] eat. We brought milkshakes in but [R6] eventually stopped drinking them..." The facility failed to ensure that R6 was provided sufficient fluids to maintain adequate hydration. There were no changes to the plan of care to increase the amount and / or frequency of offering extra fluids every shift (originally ordered 6/10/19) once R6's had lab values that indicated decreased hydration. There was no evidence that daily fluid intakes were being monitored to ensure the recommended 2,004 mLs daily was consumed. There was no evidence that the need for the Lasix was evaluated after R6's edema resolved. Findings were reviewed with E1 (NHA), E2 (DON) and E5 (QA RN) on 7/24/19 during the exit conference beginning at 1:50 PM.	F 692		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 732		9/16/19

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F 732	Continued From page 36 vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to post staffing daily in a prominent place. Findings include: 7/22/19 (7:55 AM) - During an observation upon entry into the facility on Monday (7/22/19) morning, it was observed that Friday's (7/19/19) posting was displayed. 7/22/19 (7:56 AM) - During an interview, E1 (NHA) confirmed that 7/19/19's staffing was hanging and that the staffing should have been posted over the weekend.	F 732	A. Daily staffing was posted right away on 7/22/19. B. Staffing posting was reviewed by staffing coordinator for the last two weeks and were in compliance. C. The root cause for the deficient practice was staffing posting was due to recent change in supervisor role and new supervisor was not trained regarding staffing posting daily on the weekends.	

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F 732	Continued From page 37 Findings were reviewed with E1 (NHA), E2 (DON) and E5 (QA RN) on 7/24/19 during the exit conference beginning at 1:50 PM.	F 732	All Nursing Management Staff/new hires will be in-serviced by Staff Development/Designee regarding required Staffing posting daily. On weekends, Supervisors and Nurse on Call will ensure Staffing posting is posted. Managers on Duty (MOD) will be trained by Staff Development/Designee to include in their Manager on Duty report the checking of the staffing posting on weekends. D. Daily audit of staffing posting will be conducted to ensure staffing posting is posted daily including weekends until a 100% compliance is achieved x 7 consecutive days. Following will be a weekly audit until a 100% compliance is consistently achieved x 4 evaluations, then monthly for the next quarter or until a 100% compliance is consistently achieved x 3 evaluations.. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		9/16/19

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F 758	Continued From page 38 but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic	F 758		

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F 758	Continued From page 39 drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to assess for abnormal involuntary movement (AIMS assessment) for one (R6) out of three residents sampled for psychoactive medications. Findings include: Review of R6's clinical record revealed: 6/6/19 - R6's physician standing orders included, "AIMS test on admission if on antipsychotic medication, on initiation of an antipsychotic and repeat every 6 months." 6/10/19 - A care plan was developed for R6 since "receiving antipsychotic medication related to verbal aggression (cursing / yelling at staff)..." Intervention included to monitor / record / report to physician PRN side effects and adverse reactions of psychoactive medications..." 6/11/19 - A physicians' order included an antipsychotic medication to be given at bedtime. There was no evidence that an AIMS assessment was conducted when R6 was started on an antipsychotic medication. 7/23/19 (11:10 AM) - During an interview, E7 (RN, UM) confirmed the missing AIMS assessment. Findings were reviewed with E1 (NHA), E2 (DON) and E5 (QA RN) on 7/24/19 during the exit	F 758	A. R6 was discharged. No further correction needed. B. All residents receiving anti-psychotic medication will be reviewed to ensure AIMs assessment is in place. C. The root cause of the deficient practice was no AIMS assessment was completed for a new order of anti-psychotic medications. Licensed staff did not follow the process to ensure an AIMS assessment was completed. Licensed Staff/new hires will be in-serviced by Staff Development/Designee regarding completion of AIMS assessment for residents receiving anti-psychotic medication. Clinical leadership team will meet daily in morning meeting to review the clinical dashboard and review new anti-psychotic medication orders to ensure AIMS assessment is completed. On weekends, nursing supervisor will review all orders and will ensure AIMs assessment is completed. D. Daily audit of residents with new anti-psychotic medication will be conducted to ensure AIMs assessment is	

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F 758	Continued From page 40 conference beginning at 1:50 PM.	F 758	completed until 100% compliance is achieved x 3 consecutive evaluations. Following will be a weekly audit until a 100% compliance is consistently achieved x 4 evaluations, then monthly for the next quarter or until a 100% compliance is consistently achieved x 3 consecutive evalautions. In an event where continued non compliance is consistently below the goal, Interdisciplinary Team (IDT) will meet together with the QA Committee to review the process and revision will be made to maintain and sustain compliance. Monthly audit report will be submitted to QA committee monthly for the next quarter.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Atlantic Shores

DATE SURVEY COMPLETED: July 24, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from July 22, 2019 through July 24, 2019. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 163. The survey sample totaled 10.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed July 24, 2019:F580, F585, F600, F610, F692, F732, and F758.	Cross refer to the CMS 2567-L survey completed 7/24/19 - F580, F585, F600, F610, F692, F732, F758	9/16/19

Provider's Signature N. [signature] Title NHA Date 8/22/19